	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A DULL DAY 00			(X3) DATE SURVEY COMPLETED	
		155377	A. BUILDING B. WING			10/03/	2014
NAME OF P	PROVIDER OR SUPPLIE	3	_	EET ADDRES	S, CITY, STATE, ZIP CODE	<u> </u>	
	JR CROSSING		707 S JACKSON PARK DR SEYMOUR, IN 47274				
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI TAG	CROS	ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
F000000							
	State Licensure	or a Recertification and Survey. This visit restigation of Complaint d IN00154531.	F000000	F279	uest paper IDR review for D. Facility disagrees with e and severity.		
	Complaint IN00						
	Unsubstantiated	due to lack of evidence.					
	Complaint IN00154531 - Unsubstantiated due to lack of evidence.						
	Survey dates: Se 1, 2, and 3, 2014	eptember 29, 30, October					
	Facility number Provider numbe AIM: 10027471	r: 155377					
	Survey team: Julie Dover, RN Rita Bittner, RN Tammy Forthof Josh Emily, RN	Ī					
	Census bed type SNF/NF: 93 Total: 93	::					
	Census payor ty Medicare: 7 Medicaid: 80 Other: 6	pe:					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155377	B. WING			10/03/	2014
	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR DUR, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F000241 SS=D	Total: 93 Sample: 3 These deficiencic cited in accordant 16.2-3.1. Quality review c 2014, by Janelyn 483.15(a) DIGNITY AND REINDIVIDUALITY The facility must p in a manner and ir maintains or enhadignity and respector her individuality Based on intervierecord review, the resident's dignity to requesting to I multiple times be to the resident's resi	es reflect state findings ace with 410 IAC ompleted on October 9, a Kulik, RN. ESPECT OF romote care for residents an environment that nees each resident's at in full recognition of his acceptable. ew, observation and are facility failed to ensure a was maintained related leave the dining room are fore being assisted back room for 1 of 1 random are sident #84)	F000	0241	F241 Dignity and Respect Who corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident #84 has be interviewed for her preferences regarding dining room attendance. Her plan of care he been update accordingly and preferences are being followed Social Service Director has followed up with resident regarding psychosocial well being. Therapist #4 was reeducated from her supervisor regarding resident's rights. Ho	een s nas d.	10/27/2014
		Speech Therapist #4 she			will you identify other resider		

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Event ID:

NNXN11 Facility ID: 000272

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPLETE	ED
		155377	A. BUI B. WIN	LDING		10/03/20	14
			b. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	₹			JACKSON PARK DR		
SEVMOI	JR CROSSING				DUR, IN 47274		
	·			SETIVIC			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE CO	OMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		eat in the dining room.			having the potential to be		
	The resident was	s sitting at the table for			affected by the same deficie		
	12 minutes whil	e the staff went to			practice and what corrective action will be taken? All resident		
	retrieve her dining tray from the kitchen. During the 12 minute wait, the resident				have the potential to be affect	l l	
					by the alleged deficient		
	_	ne did not feel good and			practice. All residents have be	een	
		eat in the dining room.			interviewed by SS/Designee of	on	
		with the resident's tray,			their dining preferences. Eac		
	_	• • •			resident's dining preference is		
		st #4 sat down beside the			documented in the careplan.		
		sident continued to			inservice on resident's rights a choices will be completed by	anu	
	-	herapist #4 she did not			10/24/2014. Additionally, nev	,	
	want to eat in th	e dining room, the			hire employees also receive		
	resident was the	n returned to her room			training on resident's rights ar	nd	
	without consum	ing any of her meal.			choices during orientation. W	hat	
					measures will be put into pla		
	During an interv	view with Resident #84			or what systemic changes w	rill	
	_	t 12:20 p.m., she			you make to ensure that the		
		d informed staff on			deficient practice does not		
					reoccur? All residents will be	for	
		s she had no desire to eat			interviewed using Preferences Daily Customary Routines too		
	in the dining roo	om.			which covers meal time and p		
					preference. Plan of Cares wil		
	_	view on 10/01/2014 at			updated by 10/27/14.		
	12:40 p.m., Resi	ident #84's daughter			Preferences for Daily Custom		
	indicated staff h	ad made her mother eat			Routines tool will be complete		
	in the dining roo	om on several occasions.			upon initial MDS assessment, quarterly thereafter, and upon		
		s not like to eat around			significant changes or resider		
		rs to dine in her room.			request. An inservice on	"	
	-	embers have been present			resident's rights and choices	will	
	-	vs her mother to eat in her			be completed by 10/24/2014.		
	1	vs her momer to eat in her			Additionally, new hire employ		
	room.				also receive training on reside	ent's	
					rights and choices during		
		ecord was reviewed on			orientation. How will the corrective actions be		
		10 a.m., Nutritional			monitored to ensure the		
	Status Care Plan	, indicated but was not			deficient practice will not		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155377	B. WIN			10/03/2014
NAME OF B	DROWNER OF GLIDBLIED			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			707 S J	ACKSON PARK DR	
	JR CROSSING				OUR, IN 47274	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	, The state of the	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	reoccur? The Accommodation	DATE
	_	ential for nutritional risk,			Needs audit tool will be	101
	_	reference to eat in her			completed weekly times 4 week	eks
		encouragement. Family,			then monthly times 6 months.	
	-	rotective services			Any issues found will be	
		nd resident are all aware			corrected and brought before t	he
		and risks of dining			monthly QA committee for review. Any non compliance w	vith
	without continuo	ous supervision.			staff will result in staff education and up to disciplinary action.	
	The Quarterly M	Iinimum Data Set				
	` `	OS) dated 8/16/2104				
	`	diagnoses for Resident				
		was not limited to				
		chotic disorder other than				
		VA and dementia.				
		core for the Brief				
	Interview of Mei	ntal Status was 10.				
	_	iew on 10/02/2014 at				
	10:32 a.m., MDS					
	indicated the car	e plan for Resident #84's				
	dining preference	e was to dine in her room				
	for meals.					
	During an interv	iew on 10/02/2014 at				
	1:18 p.m., Speec	h Therapist #8 indicated				
	Resident #84 wa	s observed once a day by				
		st for 35 minutes. She				
		resident does not want				
	to be in the dinin	g room, the facility will				
		late the resident's choice.				
	*	imes when a speech				
		with Resident #84 in her				
	-	herapist #8 indicated it				
	_	e resident to come out of				
	was better for the	e resident to come out of				

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	JETIPLE CO	DNSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	155377	A. BUIL	DING	00	10/03/	
		133377	B. WIN			10/03/	2014
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR		
SEYMOL	IR CROSSING				OUR, IN 47274		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA*	TE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		ndicated Resident #84					
	had an adult prot						
	•	ho makes decisions for					
	the resident.						
	During on interv	iew on 10/02/2014 at					
	_	l Service Director #9					
		its' were free to make					
		s even with appointed					
		service representative or					
	a guardian.	service representative or					
	a Baar arair.						
	3.1-3(u)(3)						
E000040	400 45(h)						
F000242 SS=D	483.15(b) SELE-DETERMIN	ATION - RIGHT TO					
00-D	MAKE CHOICES	Andre Marin 18					
	The resident has t						
		es, and health care					
	consistent with his	plans of care; interact					
		he community both inside					
		cility; and make choices					
	•	is or her life in the facility					
	that are significant	ew, observation and	FUU	0242	F242 Self Determination –		10/27/2014
		ne facility failed to ensure	1.00	0474	Right to Choices What		10/2//2014
	•	to choose his or her			corrective actions will be		
		ce for 1 of 7 residents			accomplished for those		
	• •	pices. (Resident #84)			residents found to have beer affected by the deficient	1	
	13.1034 101 0110	(1.001.001.01)			practice? Resident #84 has be	een	
	Findings include	:			interviewed for her preference		
	<i>G</i> 2				regarding dining room		
					attendance. Her plan of care l	nas	

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Event ID:

NNXN11

Facility ID: 000272

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
		155377		LDING		10/03/	2014
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF F	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE		
05)4401	ID 00000110				ACKSON PARK DR		
SEYMOU	JR CROSSING			SEYMC	DUR, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	During an observ	vation on 10/01/2014 at			been update accordingly and		
	11:42 a.m., Resi	dent #84 was transported			preferences are being followed	d.	
	•	e dining room by Speech			Social Service Director has		
		esident #84 was telling			followed up with resident		
	•	•			regarding psychosocial well being. Therapist #4 was		
		at #4 she did not want to			reeducated from her supervisor	nr	
	_	room. The resident was			regarding resident's rights. Ho		
	sitting at the tabl	le for 12 minutes while			will you identify other reside		
	the staff went to	retrieve her dining tray			having the potential to be		
	from the kitchen	. During the 12 minute			affected by the same deficier	nt	
		t was repeating she did			practice and what corrective		
		d did not want to eat in			action will be taken? All resid	ent	
	_	After returning with the			have the potential to be affecte	ed	
	_	· ·			by the alleged deficient		
	•	peech Therapist #4 sat			practice. All residents have be		
	down beside the	resident. The resident			interviewed by SS/designee of		
	continued to adv	rise Speech Therapist #4			their dining preferences. Each		
	she did not want	to eat in the dining			resident's dining preference is documented in the careplan. A		
	room, the reside	nt was then returned to			inservice on resident's rights a		
		t consuming any of her			choices will be completed by	ii iu	
	meal.	it consuming any of her			10/24/2014. Additionally, new	,	
	ilical.				hire employees also receive		
					training on resident's rights an	d	
	_	iew with Resident #84			choices during orientation. Wh	nat	
	on 10/01/2014 at	t 12:20 p.m., she			measures will be put into pla		
	indicated she had	d informed staff on			or what systemic changes w	ill	
	several occasion	s she had no desire to eat			you make to ensure that the		
	in the dining roo	m			deficient practice does not		
	v v				reoccur? All residents will be		
	Danina an intana	: 10/01/2014 at			interviewed using Preferences		
	_	iew on 10/01/2014 at			Daily Customary Routines too which covers meal time and pl		
	-	dent #84's daughter			preference. Plan of Cares will		
		ad made her mother eat			updated by 10/27/14.	~~	
	in the dining roo	m on several occasions.			Preferences for Daily Customa	ary	
	Her mother does	not like to eat around			Routines tool will be complete		
	others and prefer	rs to dine in her room.			upon initial MDS assessment,		
	_	embers have been present			quarterly thereafter, and upon		
	I	_			significant changes or residen	t	
	i me racinty anow	s her mother to eat in her	1		request. An inservice on		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLETED
		155377	A. BUII B. WIN			10/03/2014
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER				ACKSON PARK DR	
CEVMOL	ID CDOCCING					
SETIVIOL	JR CROSSING			SETIVIC	DUR, IN 47274	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	room.				resident's rights and choices w	vill
					be completed by 10/24/2014.	
	Resident #84's re	ecord was reviewed on			Additionally, new hire employe	
		10 a.m., Nutritional			also receive training on reside	nt's
		·			rights and choices during orientation. How will the	
		, indicated but was not			corrective actions be	
	_	ential for nutritional risk,			monitored to ensure the	
	•	reference to eat in her			deficient practice will not	
	room even after	encouragement. Family,			reoccur? The Accommodation	n of
	resident's adult p	rotective services			Needs audit tool will be	
	representative, a	nd resident are all aware			completed weekly times 4 wee	eks
		and risks of dining			then monthly times 6 months.	
	without continuo	•			Any issues found will be	
	**************************************	out super vision.			corrected and brought before t	ne
	The Questerly M	linimum Data Cat			monthly QA committee for review. Any non compliance v	vith
	· · · · · ·	Inimum Data Set			staff will result in staff education	
	,	OS) dated 8/16/2104			and up to disciplinary action.	
		t diagnoses for Resident				
	#84 included but	was not limited to				
	Depression, psyc	chotic disorder other than				
	schizophrenia, C	VA and dementia.				
	Resident #84's so	core for the Brief				
	Interview of Me	ntal Status was 10.				
		2001				
	During on intern	iew on 10/02/2014 at				
	10:32 a.m., MDS					
	,					
		e plan for Resident #84's				
		e was to dine in her room				
	for meals.					
	During an interv	iew on 10/02/2014 at				
	_	h Therapist #8 indicated				
		s observed once a day by				
		st for 35 minutes. She				
		resident does not want				
	to be in the dining	g room, the facility will				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION		A. BUII	LDING	00	COMPL	
		155377	B. WIN	G		10/03/	2014
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
SEYMOL	JR CROSSING				ACKSON PARK DR JUR, IN 47274		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	ECTION (X5	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	try to accommod	ate the resident's choice.					
	There had been t	imes when a speech					
	therapist had sat	with Resident #84 in her					
	room. Speech T	herapist #8 indicated it					
	was better for the	e resident to come out of					
	the room. She in	dicated Resident #84					
	had an adult prot	ective service					
	representative wl	no makes decisions for					
	the resident.						
	During an intervi	iew on 10/02/2014 at					
	1:51 p. m., Socia	1 Service Director #9					
	indicated residen	ts' were free to make					
	their own choice	s even with appointed					
		service representative or					
	a guardian.	· · · · · · · · · · · · · · · · · · ·					
	3.1-3(a)						
	,						
F000279	483.20(d), 483.20(
SS=D	PLANS	REHENSIVE CARE					
	A facility must use	the results of the					
	-	velop, review and revise					
	the resident's com	prehensive plan of care.					
	The facility must d	evelop a comprehensive					
		resident that includes					
		ives and timetables to					
		medical, nursing, and					
		osocial needs that are					
	identified in the co	mprehensive assessment.					
	The care plan mus	st describe the services					
	that are to be furni	shed to attain or maintain					
	the resident's high	est practicable physical,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	00	COMPL	ETED
		155377	B. WIN			10/03/	2014
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	₹					
CEVMOL	ID CDOSSING				IACKSON PARK DR		
SETIVIOU	JR CROSSING			SETIVIC	DUR, IN 47274		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		nosocial well-being as					
		83.25; and any services					
		ise be required under					
	l =	ot provided due to the					
		e of rights under §483.10,					
		to refuse treatment under					
	§483.10(b)(4).	-4: :	F00	0270	Request paper IDR review for		10/27/2014
		ration, interview, and	F00	0279	F279. Facility disagrees with		10/27/2014
	· ·	ne facility failed to create			scope and severity.F279 Deve	elop	
	and update an in	dividualized care plan			Comprehensive Care Plans W	-	
	with specific app	proaches for each goal as			corrective actions will be		
	resident progress	sed in treatment. This			accomplished for those		
		e effected 1 of 2 residents			residents found to have beer	,	
	reviewed. (Res				affected by the deficient		
	l leviewed. (Kes	ideii # 89)			practice? Resident #89's has		
					had a new MDS assessment		
	Findings include	:			completed which indicates leve	el	
					of assistance needed on		
	On 9/30/14 at 11	:20 a.m., Resident #89			10/27/14. Resident #89 is also		
	was observed to	ambulate from dining			on therapy caseload and has h		
		t #89 room. Resident #89			licensed occupational therapis		
					review gait assistance. Plan of Care has been updated to refle		
		air in the dining room			10/27/14 assessment. How w i		
		ce and with ease, then			you identify other residents	"	
		ane at normal speed, gait			having the potential to be		
	and balance, wit	h no assistance of staff.			affected by the same deficier	nt	
	Resident #89 rea	ached her room and sat			practice and what corrective	.	
		resident was then			action will be taken? All resid	lent	
		ng up from a sitting			have the potential to be affected	ed	
					by the alleged deficient practic		
	_	ped with ease and no			MDS Coordinator reviewed all		
		staff. Resident #89 was			MDS assessments for ADL's to	o	
	observed to return	rn to dining room in the			ensure accuracy and that the		
	same manner.				careplan reflected the accurate		
					MDS assessment.An inservice		
	On 10/1/14 at 9.	12 a.m., Resident #89			Activities of Daily Living coding		
		the hall ambulating with			and Plan of Care updating will completed by 10/24/2014 with		
		•			Nurses and Certified Nursing		
	a cane, no assista	ance from staff, with no			Aides. What measures will be	,	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLETED
		155377	B. WIN			10/03/2014
(F. 6F. F				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	R		707 S J	IACKSON PARK DR	
SEYMOL	JR CROSSING			SEYMO	DUR, IN 47274	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION)		TAG		DATE
	balance or gait i	ssues.			put into place or what system changes will you make to	mic
					ensure that the deficient	
	On 10/1/14 at 12	2:35 p.m., Resident #89			practice does not reoccur?	
	was observed w	alking down the hall to			During clinical rounds	
	room unassisted	with a cane, with normal			Monday-Friday IDT team will	
	gait and speed.				review ADL coding of residen	t
	•				that are due for	
	On 10/2/14 at 8:	:49 a.m., Resident #89			MDS assessments with line s	
		nbulating down the			(Nurses and CNA's) to ensure accuracy.MDS	
		cane, with normal gait and			Coordinator/Designee will pla	ce
	speed.	ourie, with normal gait and			accurate ADL's onto MDS	
	speed.				assessments and will update	
	0 : 10/2/14 - 42	00 m m B m 1 m 4 //00			careplans to reflect accurate	
		:00 p.m., Resident #89			coding. How will the correcti	
		aving the bathroom with			actions be monitored to ens the deficient practice will no	
		tting on the bed, and			reoccur? An ADL accuracy a	
	rising from the l	ped with no assistance.			tool that covers care plans will completed weekly times 4 we	ll be
	The record for F	Resident #89 was			then monthly times 6 months.	
		1/14 at 9:48 a.m. The			Any issues found will be	
		oses included, but were			corrected and brought before	the
		iabetes mellitus type II,			monthly QA committee for	
	· ·	lisease, dementia with			review. Any non compliance staff will result in staff educati	
		neal neuralgia, chronic			and up to disciplinary action.	
	1	• .			a separation of sections	
		nonary disease, stroke,				
	psychosis, senil					
	delusions, triger	ninai neuraigia.				
	Review of the fi	ve day Minimum Data				
	Set (MDS) Asse	essment dated 5/7/14,				
	indicated the res	sident needed limited				
		ed assistance - resident				
	`	in activity; staff provide				
	"	ering of limbs or other				
	-	ring assistance) with one				
	mon-weight-bear	ing assistance) with one				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155377				LDING	NSTRUCTION 00	(X3) DATE COMPL 10/03	ETED
	PROVIDER OR SUPPLIER JR CROSSING		•	707 S J	DDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR DUR, IN 47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	following activit walking in room locomotion off u (transfers-how re surfaces includir wheelchair, and indicated Reside extensive assistaring assistaring provide weight-hone person physicuse and personal indicated for bal was not steady, be without human a following activit to standing position assistive devices and facing the opwalking, moving surface-to-surface between bed and Review of the arrow (MDS) Assessm indicated the result assistance for trathat Resident #8 assistance with a assistance for too hygiene. MDS i	esident moves between ag to or from: bed, chair, standing position). MDS ant #89 required ance (extensive assistance and in activity, staff bearing support) with a fical assistance for toilet and hygiene. MDS ance that Resident #89 but able to stabilize assistance for the ance; moving from seated and, walking (with aff used), turning around apposite direction while ag on and off toilet, and are transfer (transfer a chair or wheelchair).					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155377				LDING	NSTRUCTION 00	(X3) DATE COMPL 10/03/	ETED
	PROVIDER OR SUPPLIER		p. ((ii)	STREET A	ADDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR JUR, IN 47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Resident #89 was tabilize without following activit to standing position assistive devices and facing the opwalking, moving surface-to-surface between bed and Physical Therapy dated 08/07/2014 Administrator or a.m., indicated pstarted on 05/02/08/07/2014. Physindicated the pattupright for ten more break, was met of the therapy notes als #89 goal of using supervision (nee physical assistant for three hundred and verbal instrus 8/5/2014. Occupational the #89, dated 08/07 Administrator or a.m., indicated of started on 05/01/01/01/01/01/01/01/01/01/01/01/01/01/	indicated for balance that is not steady, but able to human assistance for the ies; moving from seated ion, walking (with if used), turning around oposite direction while is on and off toilet, and it transfer (transfer chair or wheelchair). If notes for Resident #89 is the interpretation of the interpretat					

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[· ·		IDENTIFICATION NUMBER:		ULTIPLE CO	OO	(X3) DATE COMPL	
155377			LDING	00	10/03/		
		100077	B. WIN		A PARTICLE OF THE CORP.	10/00/	2014
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR		
SEYMOUR CROSSING					OUR, IN 47274		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
IAG		LSC IDENTIFYING INFORMATION)		TAG	DIA TELENCT)		DATE
		sident #89, patient was					
	-	all bathing tasks ision, (needs verbal					
		ysical assistance) was					
		•					
		14. Occupational dicated, Resident #89 met					
	"	gable to achieve balance de utilizing grab bars					
		ed independence,					
		or extra time needed.					
	assistive device	or extra time needed.					
	Review of care r	olan dated 11/12/2012,					
	_	proach for Resident #89					
	was an assistanc						
		concerning the problem					
		assistance with activities					
	•	elated to: decreased					
		and dementia with					
	psychosis	und dementia with					
	psychosis						
	Review of care r	olan dated 11/12/2012,					
	-	proach for Resident #89					
		e staff for transfers as					
		resident to steady herself					
		concerning the problem					
	care planned for						
	-						
	Review of reside	ent profile (resident					
	profile was infor	mation seen by staff on					
	kiosk related to 1	residents plan of care)					
	dated 10/3/2014	indicated the approach					
		was an assistance of one					
	staff for problem	of activities of daily					
	living. Approac	h for Resident #/89 of					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155377			LDING	NSTRUCTION 00	(x3) date survey COMPLETED 10/03/2014			
NAME OF PROVIDER OR SUPPLIER SEYMOUR CROSSING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 S JACKSON PARK DR SEYMOUR, IN 47274					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	indicated, for profor Resident #89 one for transfers resident to stead During an intervent p.m., Certified Massistance one or night with balant toilet. CNA #10 assistance was nassistance for baland transferring unaware of any CNA #10 indicates to see if a reside assess situation on information from the same and transferring unaware of any CNA #10 indicates to see if a reside assess situation on information from the same and transferring unaware of any CNA #10 indicates to see if a reside assess situation on information from the same and transferring unaware of any CNA #10 indicates to see if a reside assess situation on information from the same and transferring unaware of care plan. During an intervent p.m., the Minim (MDS) coordinates week on Thursday assessed by the someone should	the for mobility if ablem of falls. Approach of provide assistance of as needed, to assist by herself during transfers. I iew on 10/1/2014 at 3:00 durse Assistant (CNA) assident #89 needed at of every ten times at the while getting off the provided to Resident Hent #89 hit the call light. It is the defendent when showering in shower room but other needed assistance. It is the ten that she would, wait that asks for help, then when she got to resident, for guidance on how to CNA #10 indicated she assistance specified in the indicated, once a many Resident #89 was MDS coordinator, and be there at all times to or while on toilet.						

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X (X2) MULTIPLE		OO	(X3) DATE SURVEY COMPLETED	
155377			LDING	00	10/03/		
		100077	B. WIN		PPPPGG GYMY GM ME GYP GOPE	10/00/	2014
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE ACKSON PARK DR		
SEYMOUR CROSSING					OUR, IN 47274		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
IAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		iew on 10/2/2014 at 2:01					
	_	89 indicated, she tance with standing,					
		nygiene, or activities of					
	daily living, and	• •					
		ghout the day or night.					
	assistance unoug	shout the day of flight.					
	During an interv	iew on 10/2/2014 at 2:50					
	_	ndicated Resident #89					
		assistance at anytime,					
	I -	ncluding activities of					
	daily living, transfers or personal						
	hygiene.						
	78						
	During an interv	iew on 10/3/2014 at 9:50					
		ractical Nurse (LPN) #12					
	l '	nt #89 does not need					
	assistance and co	ompletes following the					
	tasks on her own	; dressing, bathroom					
	use/toileting, aris	sing from bed, personal					
	hygiene, transfer	ring, dressing and					
	activities of daily	y living. LPN #12					
	indicated she wa	s unaware of Resident					
	#89 's need assis	stance in care plan, and					
	unaware of what	care plan indicated for					
	Resident #89. A	fter LPN #12 reviewed					
	care plans conce	rning activities of daily					
	_	assistance of one staff					
		e plan of providing					
	assistance of one	e staff, for transfers as					
		resident to steady herself					
	during transfers,	LPN #12 indicated she					
		care planned need of					
	staff assistance f	or transferring and					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155377		(X2) MULTIPLE C A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 10/03/2014			
NAME OF PROVIDER OR SUPPLIER SEYMOUR CROSSING			STREET ADDRESS, CITY, STATE, ZIP CODE 707 S JACKSON PARK DR SEYMOUR, IN 47274				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
F000465 SS=E	indicated that the updated. LPN # #89 did not need toilet use and traset dated 8/3/2013.1-35(a) 483.70(h) SAFE/FUNCTION TABLE ENVIRON The facility must psanitary, and commerciatents, staff and Based on observed record review the provide an odor of three common areas on B Wingroom (#706). Findings include 1. Observation of 09/29/2014 at 10 strong urine odor nurse's stations of the date of the provide and the	AL/SANITARY/COMFOR rovide a safe, functional, fortable environment for d the public. ation, interview, and e facility failed to free environment for two a areas (nurse's station g and C Wing) and one : of the facility on 0:00 a.m. indicated a r in the areas around the on B Wing and C Wing. the facility on 09/30/2014 cated a strong urine odor and the nurse's stations on	F000465	F465 Safe/Functional/Sanitary/Corortable Environment What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Room #706 has be deep cleaned, also linens in the room changed out as well as a bathroom has been deep cleaned. The root cause of the common areas was identified the soiled utilities is now empt twice a shift, soiled linens are now emptied 4 times a shift at as needed if odors arise. Ventilation fans in the soiled utilities will be replaced by 10/24/14. The solid utility roo on B and C wing will be deep	en ne the de as a in tied		

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		155377	A. BUILDING			10/03/2014	
			B. WIN		ADDRESS STATE STATE SOPE		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
					ACKSON PARK DR		
SEYMOU	JR CROSSING			SEYMC	DUR, IN 47274		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG				TAG	DEFICIENCY)		DATE
					cleaned by 10/24/14. An air		
	RN #1 was inter	viewed on 10/02/2014 at			deodorizer has been added to	the	
		en asked about the urine			B wing and C wing soiled liner	1	
					rooms. How will you identify		
		around the nurse's station			other residents having the		
	_	ndicated the dirty linen			potential to be affected by the	e	
	room was near tl	ne nurse's stations in C			same deficient practice and		
	Wing and B Wir	ng and dirty linens were			what corrective action will be	•	
	removed two tim	•			taken? All resident have the		
		ios durry.			potential to be affected by the		
	Di	: 10/02/2014			alleged deficient practice. An inservice on odor control and		
	•	iew on 10/02/2014 at			environmental rounds will be		
	•	Maintenance #2, indicated			completed by 10/24/2014 with		
	the dirty linen re	ceptacles were kept			facility personnel including the		
	covered and transported to laundry at				nursing department, departme		
	least two to four times a day. He				heads, housekeeping and laur		
	indicated the facility had a contract with				department. What measures v		
	an odor control company that comes in				be put into place or what		
					systemic changes will you		
		d replaces the scent			make to ensure that the		
	cartridges.				deficient practice does not		
					reoccur? Department heads		
	Observation of the	he facility on 10/03/2014			have been assigned designate	ed	
		cated a strong urine odor			rooms and common areas to	.	
	near the C wing	-			round on daily to ensure an od		
	near the e wing	naise s station.			free environment is provided. odors are found a root cause v		
	D	10/02/2014			be identified and corrective	VIII	
	•	iew, on 10/03/2014 at			actions will be taken. How will		
	10:02 a.m., with	Maintenance #2,			the corrective actions be	' I	
	documentation r	eview of odor control			monitored to ensure the		
	company's receipts indicated air fresheners throughout the facility are refilled each month.				deficient practice will not		
					reoccur? An environmental C	QI	
					tool including odors will be	,	
					completed daily times 4 weeks	,	
					then weekly times 4 weeks, the		
	•	itial tour on 09/29/2014			monthly times 6 months. Any		
	at 10:15 a.m., a s	strong odor of urine was			issues found will be corrected		
	noted in the hall	way outside of room			brought before the monthly QA		
	#706.				committee for review. Any nor	า	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETED				
		155377	B. WING		10/03/2014			
NAME OF I	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP CODE				
SEYMOUR CROSSING			707 S JACKSON PARK DR SEYMOUR, IN 47274					
				JUR, IN 47274				
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)			
PREFIX TAG	,	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE COMPLETION DATE			
		,		compliance with staff will resu	ult in			
	During an obse	rvation on 09/29/2014 at		staff education and up to				
	1 -	#706 had a strong odor of		disciplinary action.				
	_	rom the bathroom. No						
	visible urine wa	as noted in the toilet.						
	Urine odor cou	ld be smelled in the						
	-	e the room. Two residents						
	resided in room	n #706.						
	1 -	rvation on 09/30/2014 at						
	· ·	m #706 had a strong odor						
		nallway outside of the						
		oot in diameter urine stain						
		ne bed. The resident was						
	sitting beside th	ne bed in a recliner.						
	During a secon	d observation on						
	1	2:12 p.m., Room #706						
		eve a strong odor of urine						
		outside the room. The						
	1	meter urine stain was still						
	visible on the b	ed. The resident						
	continued to sit	in her recliner next to her						
	bed.							
	3.1-19(f)							

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